

about the size of a small chestnut. From the cavity trickled a thin stream of dark blood. The ruptured cyst was curetted with gauze and the cavity obliterated with a purse-string suture. The appendix was removed although free of disease. Closure without drainage completed the operation.

A sharp febrile rise followed that evening and fell to sustained normalcy on the third day. Menstruation appeared thirty hours after the laparotomy and ran its usual course of four days. The rest of the convalescence was uneventful.

The final diagnosis was that of ruptured lutein cyst, or, as it has been termed, "apoplectic ovary". After the operation we referred to some seven quite recent textbooks seeking a description of a similar case. In only one of them, Bailey's *Emergency Surgery*, was there any clear description of the condition. The author records that he had met with the condition a number of times, but on each occasion had opened the abdomen on a hesitant diagnosis of mild acute appendicitis.

In conclusion, when one is confronted with a case of sudden, severe, lower abdominal pain in a young unmarried woman, the diagnosis of "apoplectic ovary" should be considered. If temporizing be rejected as a dangerous course, then the safe thing is to expose the adnexa as well as the appendix by means of a right rectus incision.

AN ERUPTION CLOSELY RESEMBLING LICHEN PLANUS DUE TO WHEAT GERM

By A. HAMILTON NEWMAN

Montreal

The patient, M.D., aged 47, male, developed in the spring of 1939 an intensely irritating condition of the

skin. Examination disclosed an eruption of both palms, wrists, and arms as far as the elbow, which was more marked in the flexures. On the right flank there was a patch about the size of the hand and another affecting the skin of the mid-lumbar region. On the wrists and arms the papules were for the most part discrete, but at the bend of the wrist and elbow they had a tendency to mass together and form scales. The individual papules strikingly resembled those of lichen planus, being angular, umbilicated and striated. The colour of the papules was not however quite that of lichen planus, which is purplish, but tended to a brighter, more reddish, hue. The evolution of the papules followed also a somewhat different course, appearing in tiny rounded elevations like minute shot beneath the skin and later taking on the shape and character of the papule of lichen planus. The first appearance of the eruption came on the right flank and lumbar region, later showing on the palms of hands and spreading to wrists and elbows.

At first lichen planus was the diagnosis, but in spite of treatment the condition continued to spread. Later on close questioning revealed that the patient had been taking a preparation of wheat germ and was still taking the same daily. Shortly after stopping this the eruption slowly disappeared and the itching abruptly ceased. Six weeks later it had almost disappeared. As a test wheat germ was again taken, with the result that the signs and symptoms returned; new papules appeared with intense itching.

Since the particular preparation of wheat germ the patient was taking contained the vitamins B₁, B₂, and B₆, along with vitamin E there was the question of causation by the other factors. Accordingly fresh brewers' yeast was given with no result.

Finally when the lesions had progressed to recovery wheat germ oil was administered and there was an immediate flare-up and all the signs returned. A second test under same conditions had the same result.

Clinical and Laboratory Notes

A METHOD OF CIRCUMCISION, USING THE ELECTRO-CAUTERY

By T. C. BRERETON, M.D.

Winnipeg

The first step is to retract the foreskin and free it right back of the corona as far as it will go.

The next step is to bring the foreskin back over the gland to its normal position.

Then draw the foreskin back until the junction of the skin and mucous membrane is the most anterior part of the foreskin. Now seize the upper part of the foreskin at this junction of skin and mucous membrane with a pair of artery forceps and clamp the forceps. Seize the lower part of the foreskin at the junction of the skin and mucous membrane with another pair of artery forceps and clamp on.

Next drag on both these forceps. This draws not only the skin but also the mucous surface forward at the same time. Now this drag causes

the corona of the glans penis to come into view through the mucous and skin tissue.

Then take artery forceps with a fairly long jaw, open the jaws and place one jaw on each side of the dragged out foreskin and carry the jaws back until they lie one-eighth of an inch in front of the corona of the glans penis and parallel to the corona.

Clamp this forceps and as the jaws close they force the glans back from under the artery forceps. Clamp the forceps.

Now remove the foreskin by electro-cautery at cherry-red heat by burning along the distal surface of this last forceps. This should be done rather carefully by burning only a little at a time, to prevent the forceps from becoming too hot.

As soon as the foreskin is removed unclamp the forceps and then retract the foreskin until it is back of the corona, where it should be made to stay until you are sure the wound is all healed, usually within two weeks.

No dressing is required.